

**How to Bill for Nursing Facility Add-On Code S0317
(Also known as “Medicaid Transitional Add-On”)**

Nursing Facilities Billing for Add-On Services Provided in a Nursing Facility

Beginning *January 25, 2021*, a nursing facility will be eligible for a Medicaid Transitional add-on of \$130 per member per day for the first 30 days of the FFS member’s nursing facility stay, not including any leaves of absence, if the FFS member meets all of the following criteria:

- (a) MassHealth is the FFS member’s primary payer for nursing facility services at the time of admission;
- (b) The FFS member was transferred to the nursing facility directly from an acute inpatient hospital on or after *January 25, 2021*; and
- (c) The FFS member is not returning to the nursing facility from a medical leave of absence.

Nursing facilities should submit claims for the add-on services directly to MassHealth as indicated below.

BILL NURSING FACILITY ADD ON RATE USING AN INSTITUTIONAL 837I OUTPATIENT CLAIM

These are the values that are different than what a Nursing Facility normally bills for.

On the 837I transaction enter a Type of Bill TOB: **231**

Use a Revenue Code: **0220 Special Charges General Classification**

With a HCPCS Code: **S0317 DISEASE MANAGEMENT PROGRAM; PER DIEM**

Enter the total number of Days

IF BILLING ELECTRONICALLY ON THE INSTITUTIONAL 837I

Image from page 145 of the 837I Guide, annotated to instruct billers to use Type of Bill Code 231

ASC X12N • INSURANCE SUBCOMMITTEE
TECHNICAL REPORT • TYPE 3

005010X223 • 837 • 2300 • CLM
CLAIM INFORMATION

REQUIRED CLM05 C023 **HEALTH CARE SERVICE LOCATION INFORMATION** O 1
To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered

REQUIRED CLM05 - 1 1331 **Facility Code Value** M AN 1/2
Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services.

IMPLEMENTATION NAME: Facility Type Code

REQUIRED CLM05 - 2 1332 **Facility Code Qualifier** O ID 1/2
Code identifying the type of facility referenced
SEMANTIC:
C023-02 qualifies C023-01 and C023-03.

CODE DEFINITION

A Uniform Billing Claim Form Bill Type
CODE SOURCE 236: Uniform Billing Claim Form Bill Type

REQUIRED CLM05 - 3 1325 **Claim Frequency Type Code** O ID 1/1
Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type



IMPLEMENTATION NAME: Claim Frequency Code

CODE SOURCE 235: Claim Frequency Type Code

Image from page 284 of the 837I Guide to instruct billers on the use of Value Code 24

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.	M 1
REQUIRED	HI01 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M ID 1/3
			CODE	DEFINITION
			BE	Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes
REQUIRED	HI01 - 2	1271	Industry Code Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.	M AN 1/30
			IMPLEMENTATION NAME: Value Code	

ENTER VALUE
CODE 24

Image from pages 424, 425, and 426 of the 837I Guide, annotated to instruct billers on the use of Revenue Code 220 and corresponding HCPCS code

005010X223 • 837 • 2400 • SV2
 INSTITUTIONAL SERVICE LINE

ASC X12N • INSURANCE SUBCOMMITTEE
 TECHNICAL REPORT • TYPE 3

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	SV201	234	Product/Service ID Identifying number for a product or service SYNTAX: R0102 SEMANTIC: SV201 is the revenue code. IMPLEMENTATION NAME: Service Line Revenue Code See Code Source 132: National Uniform Billing Committee (NUBC) Codes.	X 1 AN 1/48
				
REQUIRED	SV202 - 1	235	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234) SEMANTIC: C003-01 qualifies C003-02 and C003-08. IMPLEMENTATION NAME: Product or Service ID Qualifier and Supply Codes Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC. CODE SOURCE 130: Healthcare Common Procedural Coding System	M ID 2/2
				
REQUIRED	SV202 - 2	234	Product/Service ID Identifying number for a product or service SEMANTIC: If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs. IMPLEMENTATION NAME: Procedure Code	M AN 1/48
				
REQUIRED	SV203	782	Monetary Amount Monetary amount SEMANTIC: SV203 is the submitted service line item amount. IMPLEMENTATION NAME: Line Item Charge Amount This is the total charge amount for this service line. The amount is inclusive of the provider's base charge and any applicable tax amounts reported within this line's AMT segments.	O 1 R 1/18
				

Image from page 428 of the 837I Guide, annotated to instruct Billers on inputting of required Days

005010X223 • 837 • 2400 • SV2
INSTITUTIONAL SERVICE LINE

ASC X12N • INSURANCE SUBCOMMITTEE
TECHNICAL REPORT • TYPE 3

REQUIRED SV204 355 **Unit or Basis for Measurement Code** X 1 ID 2/2
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

ENTER DA

SYNTAX: P0405

CODE	DEFINITION
DA	Days
UN	Unit

REQUIRED SV205 380 **Quantity** X 1 R 1/15
Numeric value of quantity

ENTER #
OF DAYS

SYNTAX: P0405

IMPLEMENTATION NAME: Service Unit Count

The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.

SEGMENT DETAIL

NM1 - ATTENDING PROVIDER NAME

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES				
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	M 1 ID 2/3				
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>71</td> <td>Attending Physician When used, the term physician is any type of provider filling this role.</td> </tr> </tbody> </table>	CODE	DEFINITION	71	Attending Physician When used, the term physician is any type of provider filling this role.	
CODE	DEFINITION							
71	Attending Physician When used, the term physician is any type of provider filling this role.							
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1 ID 1/1				
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Person</td> </tr> </tbody> </table>	CODE	DEFINITION	1	Person	
CODE	DEFINITION							
1	Person							
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1 AN 1/60				
			IMPLEMENTATION NAME: Attending Provider Last Name					
SITUATIONAL	NM104	1036	Name First Individual first name	O 1 AN 1/35				
			SITUATIONAL RULE: Required when the person has a first name. If not required by this implementation guide, do not send.					
			IMPLEMENTATION NAME: Attending Provider First Name					
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial	O 1 AN 1/25				
			SITUATIONAL RULE: Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.					
			IMPLEMENTATION NAME: Attending Provider Middle Name or Initial					
NOT USED	NM106	1038	Name Prefix	O 1 AN 1/10				
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name	O 1 AN 1/10				
			SITUATIONAL RULE: Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.					
			IMPLEMENTATION NAME: Attending Provider Name Suffix					

SITUATIONAL

NM108

66

Identification Code Qualifier

X 1 ID 1/2

Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

SITUATIONAL RULE: *Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.*

OR

Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.

OR

Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.

If not required by this implementation guide, do not send.



CODE	DEFINITION
XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare and Medicaid Services National Provider Identifier

POSC SCREEN SHOTS IF MANUALLY BILLING VIA DIRECT DATA ENTRY (DDE)

Health and Human Services Mass.gov

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Home > Billing and Service Confirmation > Extended Services > Coordination of Benefits > Procedure > Attachments

Billing Information

Previous ICN

Type of Bill * 231 - Skilled Nursing Billing Provider Taxonomy

Billing Provider ID * 1234567890123 ABC NURSING HOME

Member ID * 123456789101 Patient Account # * ADD ON CODE

Last Name * LAST First Name * FIRST NI

DOB * 03/13/1933 Gender * F - Female

Member Address 1 * 1 PARK PLACE Member State * MA - Massachusetts

Member Address 2

Member City * BOSTON Member Record #

Member Zip *

MUST INDICATE ATTENDING PROVIDER

Attending Phys Last Name * LAST Attending Phys First Name * FIRST

Attending Phys NPI * 1234567890

Assignment of Benefits Ind * Yes

Provider Accepts Assignment * A - Assigned

Claim Filing Indicator * MC - MEDICAID

Release of Information * Y - Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

From Date * 12/01/2020 Through Date * 12/30/2020

Patient Status * 30 - STILL PATIENT

Admit or Visit Source * 4 - Transfer from a hospital

Admission or Visit Type * 3 - ELECTIVE Admission Date * 12/01/2020

Admission Hour * Discharge Hour * 00

Delay Reason Code *

Total Charges * \$3,900.00 Patient Responsibility

* Patient Account Number field: type in the Patient Account Number

List of Values

There is a maximum of 24 value codes.

Code	Value
MEDICAID RATE CODE	3900

[New Item](#)

Value Code Details

Value Code * Value *

- > [Manage Service Authorizations](#)
- > [Manage Correspondence and Reporting](#)
- > [Manage Members](#)
- > [Manage Claims and Payments](#)
 - > [Enter Single Claim](#)
 - > [Inquire Claim Status](#)
 - > [View PACE Payments](#)
 - > [View SCO Payments](#)
- > [Manage Provider Information](#)
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- > [Reference Publications](#)
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List of Institutional Services

There is a maximum of 999 institutional service detail records.

Detail	Rev Code	Service Date Range	HCPCS Procedure	Units	Charges
01	0220	12/01/2020 - 12/30/2020	S0317	30	\$3,900.00

[New Item](#)

Institutional Service Detail

Detail 01

Revenue Code *

HCPCS Procedure Code 

Modifier 1  Modifier 2 

Modifier 3  Modifier 4 

From Date of Service  To Date of Service 

Units *

Units of Measurement * 

Charges * Co-pay